MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05611

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince Georges

City or town Glenn Dale
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Glenn Dale Sanatorium

Stay in hospital or inst. (yrs., or mos., or days) 3 mos. 23 dys

Stay in this community (yrs., or mos., or days) 3 mos. 23 dys

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State D.C. County

City or town Washington Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 48 Eye St., N.W.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME William Anderson Africa

3. (b) Social Security Number 577-166-205

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ or wife Irma Hahn Africa

6(c) If alive, give age unknown years

7. Birth date of deceased (mo., day, yr.) July 14, 1912

8. AGE: Years 27 | Months 9 | Days 22 | If less than one day ____ hrs. ____ min.

9. Birthplace Altoona, Pennsylvania
(Town, county, and state)

10. Usual occupation Barber

11. Industry or business Barber

FATHER
12. Name Lawrence Africa
13. Birthplace Pennsylvania

MOTHER
14. Maiden name Elsie Brantner
15. Birthplace Pennsylvania

16. Informant Deceased

Address 48 Eye St. N.W. Washington, D.C.

17. Removal to
(Burial, cremation, or removal. Which?)

Date thereof May 7, 1940
(month) (day) (year)

Cemetery or crematory

Location Washington, D.C.

18. Funeral director W W Chambers Co.

Address 517 11-St., S.E.

19. May 7th 1940
(Date rec'd by registrar)

Leo V. McMeide M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1940, at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 13, 1940, to May 6 1940, and that I last saw him alive on May 6 1940.

Immediate cause of death: Pulmonary Tuberculosis

Due to

Due to Syphilis

Other conditions
(Include pregnancy within 3 months of death)

Major findings:

Dt operations

Dt autopsy

CURATION: 7 months from history; 1 yr. from history

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work? ____

23. SIGNATURE Daniel Leo Finnisane M.D.
M. D. or other

Address Glenn Dale Sanatorium Date signed 5/6/40

Glenn Dale, Md.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 10 1940
BUREAU A. E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-c) CB

05612

CERTIFICATE OF DEATH

Reg. Dist. No. 237

1. PLACE OF DEATH:

County Prince George

City or town Aquasco

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: State Road

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) Transient

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County

City or town Washington Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 1010 Park Rd NW

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Julius Robert Arnold

3. (b) Social Security Number

4. Sex Male

5. Color or race Colored

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Maude Arnold

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1898

8. AGE: Years 41 Months 11 Days 17 If less than one day hrs. min.

9. Birthplace Greenville S.C. (Town, county, and state)

10. Usual occupation Tapi Driver

11. Industry or business

FATHER 12. Name John Arnold

13. Birthplace S.C.

MOTHER 14. Maiden name Sallie Arnold

15. Birthplace S.C.

16. Informant Maude Arnold

Address 1010 Park Rd NW DC

17. ~~Burial~~ Removal Date thereof May 25/40 (month) (day) (year)

(Burial, cremation, or removal, Which?)

Cemetery or crematory Adams & Smart Funeral Home

Location 2425 Nichols av. S.C.

18. Funeral director Andrew J. Grimes

Address Aquasco Md.

19. May 25th 1940 Henry B. Contee

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1940, at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death Burned to death

DURATION

Due to

Due to

Other conditions This body was almost completely charred leaning on

(Include pregnancy within 3 months of death)

Major findings of operations Passenger in a car that struck a bridge and caught on fire

Accidents

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide accident Date of 5-24-40

Where did injury occur? Aquasco Prgeo Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public Road

Means of injury Injured at work?

23. SIGNATURE James H. Boyd M. D. or other

Address Forestville Md Date signed 5-24-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 12 1940
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

05613

1. PLACE OF DEATH:

County Prince Georges

City or town Glenn Dale

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Glenn Dale Sanatorium

Stay in hospital or inst. (yrs., or mos., or days) 7 mos. 20 dys

Stay in this community (yrs., or mos., or days) 7 mos. 20 dys

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County

City or town Washington Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 1528 - 8th St. N.W.

(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR no

3. (a) FULL NAME Bob Baker

3. (b) Social Security Number 579-16-9525

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife none

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Aug. 29, 1909

8. AGE: Years	Months	Days	If less than one day
30	8	19	____ hrs. ____ min.

9. Birthplace Orangeburg - South Carolina (Town, county, and state)

10. Usual occupation Taxi Cab Driver

11. Industry or business

FATHER
12. Name Loney Baker
13. Birthplace Unknown

MOTHER
14. Maiden name Lossie Jones
15. Birthplace South Carolina

16. Informant Deceased

Address 1528 - 8th St. N.W. Wash, D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof May 18, 1940 (month) (day) (year)

Cemetery or crematory

Location Washington, D.C.

18. Funeral director M. T. Malvan

Address 424 - R St NW

19. May 18 1940 Lev V Schneider M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1940, at 3:09 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 28 1939, to May 18 1940, and that I last saw him alive on May 18, 1940.

Immediate cause of death Pulmonary Tuberculosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy —

DURATION 7 months from history

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel Leo Finucane M.D. M. D. or other

Address Glenn Dale Sanatorium Date signed 5/18/40

Glenn Dale, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

05614

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince George
City or town: Edmonston
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 54 Prince Edward st.
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 15 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: P. Geo.
City or town: Edmonston Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 54 P. Edward.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Bessie Barry.

3. (b) Social Security Number: None

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married.
6 (b) Name of husband or wife: Nickolas Barry
6(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Feb 4, 1877.
8. AGE: Years: 63 Months: 3 Days: 9 If less than one day: hrs. min.
9. Birthplace: Ireland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At Home.
FATHER 12. Name: Unknown
13. Birthplace: Ireland
MOTHER 14. Maiden name: Unknown
15. Birthplace: Ireland.
16. Intermant: Nicholas Barry
Address: 54 P. Ed. st., Edmonston, Md.
17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) (day) (year) 5-16-40
Cemetery or crematory: Fort Lincoln Cem.
Location: P. Geo. Co., Md.
18. Funeral director: F. Gasch's Sons.
Address: Hyattsville, Md.
19. (Date rec'd by registrar) May 15 19 40 Mrs. Jas. Severe Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5-13 19 40, at 6 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-13 19 40, to 5-13 19 40, and that I last saw h— alive on 5-13 19 40.

Immediate cause of death: Coronary Thrombosis — DURATION: 16 hrs.
Due to:
Due to:
Other conditions: Hypertension
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: injured at work?

23. SIGNATURE: Jno and Hays M. D. or other
Address: Hyatts - Md. Date signed 5-15-40

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JUN 3 1929
BUREAU T. S.

05615

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-b)

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH:

County Prince Geo

WITHIN CORPORATE LIMITS OF

City or town Laurel

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State Md County Prince Geo

City or town Laurel Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary E. Beall

3.(b) Social Security Number

4. Sex F

5. Color or race W

6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife Joseph Beall

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 25 - 1872

8. AGE: Years 78 | Months 2 | Days 12 | If less than one day ..... hrs. ..... min.

9. Birthplace Montgomery Co Md (Town, county, and state)

10. Usual occupation housewife

11. Industry or business

FATHER 12. Name Wilcox

13. Birthplace Md.

MOTHER 14. Maiden name unknown

15. Birthplace Md

16. Informant Mrs Stella Frowe

Address Laurel Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 8th 1940 (month) (day) (year)

Cemetery or crematory Union Cemetery

Location Burtonsville Md

18. Funeral director Lloyd Raiser

Address Laurel Md.

19. May 8 1940 (Date rec'd by registrar) Cora E. Wachter Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 6 1940, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 8 1940, to 5 6 1940 and that I last saw her alive on 5 6 1940

Immediate cause of death Acute Cardiac Dilitation — DURATION 0 6-40

Due to Cerebral Hemorrhage — 4-8-40

Due to Arteriosclerosis Hypertension Diabetes

Other conditions Chr Nephritis

(Include pregnancy within 8 months of death)

Major findings of operations —

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B P Warren M. D. or other

Address Laurel Md Date signed 5-7-40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

05616

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince George
City or town: Hyattsville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Sacred Heart Home
Stay in hospital or inst. (yrs., or mos., or days): 2½ yrs.
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 738 - 5 St. N.W.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: No ✓

3. (a) FULL NAME: Peter M. Becker

3. (b) Social Security Number:

4. Sex: Male
5. Color or race: white
6. (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband ~~or wife~~: Mary Walsh Becker
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Jan 2, 1855

8. AGE: Years: 85 Months: 4 Days: 15 If less than one day: ____ hrs. ____ min.

9. Birthplace: Ohio (Town, county, and state)
10. Usual occupation: Printer
11. Industry or business: Govt. Printing Office

FATHER
12. Name: Peter Becker
13. Birthplace: Germany

MOTHER
14. Maiden name: Margaret Weismantel
15. Birthplace: Germany

16. Informant: Peter Becker (son)
Address: 3209 - Stevenson Pl. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 20 1940 (month) (day) (year)
Cemetery or crematory:
Location: St. Marys Cemetery Rockville, Md.

18. Funeral director: Wm. Reuben Pumphrey
Address: Bethesda, Md.

19. May 17 1940 (Date rec'd by registrar) Jas Sevry Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17 1940, at 3 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 20 1939, to May 17 1940, and that I last saw him alive on May 17 1940.

Immediate cause of death: Acute cardiac dilatation — DURATION: 1 day
Due to: generalized arteriosclerosis — 10 years
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Thomas E. Mattingly MD M. D. or other
Address: 2200 R. Ave N.E. D.C. Date signed: 5/17/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JUN 5 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

05617

1. PLACE OF DEATH (95-2) Social Sec No. ???

County Prince Georges Registration Dist. No. 231

Village or City Brentwood Md. No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Mr. John Washington Bell If U. S. Veteran, specify WAR

(a) Residence: No. 3702 Fenwick St. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	Wh.	widower

5e. If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Emma Agnes Fletcher (Bell)

6. DATE OF BIRTH (month, day, and year) July 18, 1876

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	10	4	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Retired

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Church sexton

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Virginia

FATHER

13. NAME Mr. Albert Bell

14. BIRTHPLACE (city or town) (State or country) Va.

MOTHER

15. MAIDEN NAME unk.

16. BIRTHPLACE (city or town) (State or country) unk.

(Dau)

17. INFORMANT Mrs. Margaret Virginia Crist
(Address) 3702 Fenwick St. Br. md.

18. BURIAL, CREMATION, OR REMOVAL
Place Forest Lawn Cem Date May 25, 1940

19. UNDERTAKER J. Gasch & Son
(Address) Hyattsville Md.

20. FILED May 22, 1940 M. D. Richardson
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH May (Month) 22 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from 1-14, 1939, to 5-22, 1940

I last saw h~~im~~ alive on 5-22, 1940; death is said to have occurred on the date stated above, at 5 a.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Acute cardiac decompensation	

Other Contributary Causes of importance:

Hypertension	

Name of operation none Date of

What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Menner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Maurice D. Rosenberger M. D.

(Address) Mt. Rainier, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

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Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (191-a)

05618

CERTIFICATE OF DEATH

Reg. Dist. No. 242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Prince Georges

City or town Capital Heights
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 233 Ottawa Ave

Stay in hospital or Insf. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 18 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Capital Heights Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 233 Ottawa Ave
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Ida Elizabeth Blake

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Charles Blake

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20, 1868

8. AGE: Years 71 | Months 10 | Days 27 | If less than one day ____ hrs. ____ min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name John Thomas Lovejoy

13. Birthplace District of Columbia

MOTHER 14. Maiden name Rebecca Hurley

15. Birthplace Maryland

16. Informant Mrs Ellis Gray

Address Capital Heights Md

17. Removal. (Burial, cremation, or removal. Which?) Date thereof 5-17-40 (month) (day) (year)

Cemetery or crematory

Location Washington D.C.

18. Funeral director W W Chambers Co.

Address 542-11 st SE. W. D.C.

19. 5-17 (Date rec'd by registrar) 1940 Rene A. Conner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1940, at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____, and that I last saw h____ alive on ____ 19____.

Immediate cause of death	DURATION
Acute congestive heart failure	
Due to Cardio vascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James E. Boyd M.D. or other

Address Forestville Md Date signed 5-17-40

RECEIVED
JUN 5 1940
BUREAU Y. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186-22

05619

CERTIFICATE OF DEATH

Reg. Dist. No. 246

1. PLACE OF DEATH:

County Prince Georges.

City or town Mt. Rainier

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 2850 - 32nd St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

WITHIN CORPORATE LIMITS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn Infants give residence of mother)

State Maryland. County Prince Georges

City or town Mt. Rainier Md. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 3850 - 32nd St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Sarah Odell Bremmerman

3. (b) Social Security Number none

4. Sex: F.

5. Color or race: W.

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Jno. S. Bremmerman

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): May 17. 1852

8. AGE: Years 87 | Months | Days | If less than one day ____ hrs. ____ min.

9. Birthplace: Wash. D.C. (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER: 12. Name: Wm. Odell

13. Birthplace

MOTHER: 14. Maiden name: Unknown

15. Birthplace

16. Informant: Geo S. Bremmerman

Address: 3850 - 32nd St. Mt. Rainier

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 4th 1940. (month) (day) (year)

Cemetery or crematory: Rock Creek ~~Cemetery~~

Location: Washington D.C.

18. Funeral director: W. W. Chambers Co.

Address: Riverdale Md.

19. 0/2 (Date rec'd by registrar) 19 to Harry Lalley M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1st 1940, at 5:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1940, to May 1 1940, and that I last saw her alive on April 29 1940.

Immediate cause of death: Arteriosclerotic Cardio-vascular disease

Due to: Fracture of femur due to accidental

Due to fall; in her home. C.W.G.R.

Other conditions: Fractured Right Femur

(Include pregnancy within 3 months of death)

Major findings: —

Of operations

Of autopsy —

DURATION: 5+ years; 10 weeks

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accidents. Date of March 1st, 1940.

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) in her home.

Means of injury — Injured at work?

23. SIGNATURE: J. E. Morris M. D. or other

Address: 35 N Y Ave N.W. Date signed 5-1-40

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JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (33a)

05620

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince Georges County

City or town: Melrose Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Rhode Island ave

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 20 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Pro Geo County

City or town: Melrose Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Rhode Island ave
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: --

3. (a) FULL NAME: Laura Agnes Brown

3. (b) Social Security Number: none

4. Sex: female

5. Color or race: colored

6. (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: --

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 26, 1864

8. AGE: Years: 76 years | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: nurse

11. Industry or business:

FATHER
12. Name: Phillip Brown
13. Birthplace: Md.

MOTHER
14. Maiden name: Unknown (Contee ?)
15. Birthplace: Unknown

16. Informant: Ambrose Brown
Address: Box 42 Bladensburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 27, 1940 (month) (day) (year)

Cemetery or crematory: Mt. Olivet Cemetery

Location: Washington D. C.

18. Funeral director: F. Gasch's Sons
Address: Hyattsville Md.

19. May 26 1940 (Date rec'd by registrar) F. McNorgle Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 23, 1940 19 , at 9.40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 16 1940, to May 16 1940 and that I last saw her alive on May 16 1940

Immediate cause of death: Paralysis fm Cerebral Hemorrhage — DURATION: 2 yrs.

Due to:

Due to:

Other conditions: General Debility
(Include pregnancy within 3 months of death)

Major findings: —

Of operations:

Of autopsy: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R. A. Bennett M. D. or other

Address: Riverdale Md Date signed: May 25 1940

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05621

Reg. Dist. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Prince Georges
City or town Glenn Dale
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Glenn Dale Sanatoriums
Stay in hospital or inst. (yrs., or mos., or days) 1 yr. 2 mos. 28 days
Stay in this community (yrs., or mos., or days) 1 yr. 2 mos. 28 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D. C. County
City or town Washington Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 230-2nd St. N. E.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME Ruth Bruce

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Ernest Bruce
6(c) If alive, give age ~~Unknown~~ years

7. Birth date of deceased (mo., day, yr.) February 1914

8. AGE: Years 26 | Months | Days | If less than one day ____ hrs. ____ min.

9. Birthplace Orangeburg, South Carolina
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name William Grant
13. Birthplace Orangeburg, South Carolina

MOTHER
14. Maiden name Dennis Grant
15. Birthplace Orangeburg, South Carolina

16. Informant Husband
Address 230-2nd St. N.E. Washington, D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 5/7/40 (month) (day) (year)

Cemetery or crematory
Location Washington, D.C.

18. Funeral director Robert Campbell
Address 423-4th St., S.W. Wash., D.C.

19. May 7th 1940 Le V. McMeide M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6th 1940, at 6:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 8, 1939, to May 6 1940, and that I last saw her alive on May 6 1940.

Immediate cause of death
Pulmonary Tuberculosis — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) ____ (County) ____ (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work? ____

23. SIGNATURE Daniel Leo Finucane M.D.
M. D. or other
Address Glenn Dale Sanatorium Date signed 5/6/40
Glenn Dale, Md.

RECEIVED
JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (170-C) CP

05622

CERTIFICATE OF DEATH

Reg. Dist. No. 237

1. PLACE OF DEATH:
County Prince Georges
City or town Aquasco
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: State road
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) Transient

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State DC County
City or town Washington DC Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 1032 N J Ave NW
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME Anna Bryant

3. (b) Social Security Number

4. Sex: Female
5. Color or race: Colored
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Alfred Bryant
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): Nov 9, 1918

8. AGE: Years 21 | Months 6 | Days 15 | If less than one day ____ hrs. ____ min.

9. Birthplace: Washington D.C. (Town, county, and state)
10. Usual occupation: Cook
11. Industry or business
FATHER
12. Name: Walter Millikin
13. Birthplace: Maryland
MOTHER
14. Maiden name: unknown ✓
15. Birthplace: " ✓
16. Informant: Sylvester Berryman
Address: 1032 N J Ave NW Wash DC
17. Removal (Burial, cremation, or removal. Which?) Date thereof May 25/40 (month) (day) (year)
Cemetery or crematory: Washington D.C.
Location: Frazier Funeral Home
18. Funeral director: C. J. Grimes
Address: Aquasco Md
19. May 25th 1940 (Date rec'd by registrar) Henry B. Contee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1940, at 3 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h____ alive on ____ 19__.

Immediate cause of death: Burned to death
Due to: Passenger in an automobile that collided with a bridge and caught on fire
Due to:
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of 5-24-40
Where did injury occur? Aquasco Pr Geo (City or town) (County) Md (State)
Injured at home, farm, industry, public place (where?) State road
Means of injury Injured at work? no

23. SIGNATURE James I. Boyd M. D. or other
Address Forestville Md Date signed 5-25-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 12 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05623

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George
City or town: Glenn Dale
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Glenn Dale Sanatorium
Stay in hospital or inst. (yrs., or mos., or days): 8 mos. 2 das
Stay in this community (yrs., or mos., or days): 8 mos. 2 das.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: District of Columbia County:
City or town: Washington Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 838 New Hampshire Ave., N.W.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: No

3. (a) FULL NAME: Burt L. Campfield

3. (b) Social Security Number: 578-07-9583

4. Sex: Male
5. Color or race: Colored
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of ~~husband or~~ wife: Ruth Campfield
6 (c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): Feb. 19, 1906

8. AGE: Years: 34 Months: 2 Days: 26 If less than one day: ____ hrs. ____ min.

9. Birthplace: Aiken S. Carolina (Town, county, and state)
10. Usual occupation: Cook
11. Industry or business: —
FATHER
12. Name: —
13. Birthplace: S. Carolina
MOTHER
14. Maiden name: Winnie Lott
15. Birthplace: S. Carolina
16. Informant: Deceased
Address: above
17. Removal (Burial, cremation, or removal. Which?) Date thereof 5/16/40 (month) (day) (year)
Cemetery or crematory: —
Location: Washington D.C.
18. Funeral director: Joseph C. Jamfr
Address: 441-22 St. N.W.
19. May 16th 1940 (Date rec'd by registrar) Leo V. Schneider M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15 1940, at 9.40 p.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 13 1939, to May 15 1940, and that I last saw him alive on May 15 1940.

Immediate cause of death: Pulmonary Tuberculosis — DURATION: about one yr.
Due to:
Due to:
Other conditions: None
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale Sanatorium Glenn Dale, md. Date signed: 5/15-4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 4 1940
U.S.

STATE OF MARYLAND—CERTIFICATE OF DEATH 05624

(46-G)

1. PLACE OF DEATH

County Prince George Registration Dist. No. 230

Village or City College Park No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Charles Philip Close If U. S. Veteran, specify WAR

(a) Residence: No. 404 Rhode Island ave St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	white	Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Margaret Blandy Close

6. DATE OF BIRTH (month, day, and year) Jany 21, 1868

7. AGE Years	Months	Deys	If LESS than 1 day, hrs. or min.
72	3	20	

OCCUPATION

8. Trede, profession, or particular kind of work done, es SPINNER, SAWYER, BOOKKEEPER, etc. Scientist

9. Industry or business in which work wes done, es SILK MILL, SAW MILL, BANK, etc. U. S. Horticultural dept

10. Date deceased last worked et this occupation (month and year) 40yrs

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) New Buffalo. (State or country) Mich

FATHER

13. NAME Chas Close

14. BIRTHPLACE (city or town) Baden (State or country) Germany

MOTHER

15. MAIDEN NAME Caroline Kabelin

16. BIRTHPLACE (city or town) Baden (State or country) Germany

17. INFORMANT Margaret B Close (Address) College Park

18. BURIAL, CREMATION, OR REMOVAL Place Burial Date May 22, 1940

19. UNDERTAKER L. Gawlick Son (Address) Hyattsville Md

20. FILED May 21, 1940 John D. Smith Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH May (Month) 19 (Day) 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Mch 1st, 1936, to May 19th, 1940

I last saw h-im alive on May 19th, 1940; death is said to have occurred on the date stated above, et 5.25 P. m.

The **PRINCIPAL CAUSE OF DEATH** end related causes of Importance were as follows:

	Date of onset
Chronic Endocarditis	4yrs
Arterio sclerosis	"
Carcinoma of Pancreas	1-1-40

Other **Contributory Causes** of importance:

Neme of operation None Date of

What test confirmed diegnosis? Wes there en autopsy?

23. If death was due to external causes (VIOLENCE) fill In also the following:

Accident, suicide, or homicide? No, Date of injury 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Menner of injury

Neture of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) J. Clarence M. D.

(Address) Berwyn

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at **school** or at **home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

RECEIVED JUN 4 1940 BUREAU V. S.

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243 — 05625

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Glenn Dale Sanatorium
Stay in hospital or inst. (yrs., or mos., or days): 1yr 11mo 346 days
Stay in this community (yrs., or mos., or days): Life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 711 F. Street N.E.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: No

3. (a) FULL NAME: ~~Othelia Mae~~ Coin, Othelia Mae

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married (Separated)

B (b) Name of husband or wife: Robert J. Coin
6(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): Dec. 12 1908

8. AGE: Years	Months	Days	If less than one day
31	4	21	____ hrs. ____ min.

9. Birthplace: Washington D.C.
(Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business: Dry cleaning store
FATHER 12. Name: Peter J. Fisher
13. Birthplace: Virginia
MOTHER 14. Maiden name: Sarah A. Rockford
15. Birthplace: Ireland
16. Informant: Hospital record
Address
17. Removal (Burial, cremation, or removal. Which?) Date thereof: 5-3-40 (month) (day) (year)
Cemetery or crematory: —
Location: Washington, D.C.
18. Funeral director: W.W. Chambers
Address: 517 11th St S.E.
19. MAY 3rd 1940 (Date rec'd by registrar) Leo V. Ollinde M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: ~~April~~ May 3 1940, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-22-38 1940, to May 3 1940, and that I last saw her alive on May 3, 1940 1940.

Immediate cause of death	DURATION
Pulmonary tuberculosis	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy: Pulmonary tuberculosis

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Lee Pincare M.D. (M. D. or other)
Address: Glenn Dale Sanatorium Date signed: 5/7/40
Glenn Dale, Md.

RECEIVED
JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05626

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Glenn Dale Sanatorium

Stay in hospital or inst. (yrs., or mos., or days): 2 - 7 - 1

Stay in this community (yrs., or mos., or days): 2 - 7 - 1

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 1519 - 27th St. N.W.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: ✓

3. (a) FULL NAME: Cynthia Colbert

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	colored	Single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 15 - 1915

8. AGE: Years	Months	Days	If less than one day
24	5	5	hrs. min.

9. Birthplace: Washington D. C.
(Town, county, and state)

10. Usual occupation: Laundress

11. Industry or business: Laundry

FATHER
12. Name: Frank Colbert
13. Birthplace: Maryland

MOTHER
14. Maiden name: Lorene Fryl
15. Birthplace: Virginia

16. Informant: Deceased + Hosp Records.

Address:

17. Removal (~~Burial, cremation~~, or removal, Which?) Date thereof: May 20, 1940 (month) (day) (year)

Cemetery or crematory:

Location: Washington D.C.

18. Funeral director: Wernest Jarvis

Address: 1432 - Yorkville

19. May 20th 1940 (Date rec'd by registrar) Leo V. Schneider M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May - 20 - 1940, at 12 15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 19 1937, to May 20 1940, and that I last saw her alive on May 20 1940.

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 5 yr - 5 mo.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy: Pulmonary Tuberculosis

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale Sanatorium Date signed: 5/20/40

Glenn Dale, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 29 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

05627

CERTIFICATE OF DEATH

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Prince George

City or town Riverdale (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 10 Lincoln ave.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State County

City or town Washington D.C. Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 1427 Chapin St. NW. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME Myrta Crowell

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	Divorced

6 (b) Name of husband or wife Ned Crowell

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1886.

8. AGE: Years	Months	Days	If less than one day
53	7	4	hrs. min.

9. Birthplace Ohio (Town, county, and state)

10. Usual occupation Practitioner

11. Industry or business

FATHER 12. Name Clayton Nichols

13. Birthplace Ohio

MOTHER 14. Maiden name Ida Garrett

15. Birthplace Ohio

16. Informant Chas R. Seelye

Address 10 Lincoln ave, Riverdale Md

17. Cremation (Burial, cremation, or removal. Which?) Date thereof May 21 1940 (month) (day) (year)

Cemetery or crematory Fort Lincoln

Location Bladensburg Rd, Colmar Manor Md

18. Funeral director W. W. Chambers Co

Address 418 Cleveland Ave, Riverdale Md.

19. May 20 1940 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1940, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 1940, to May 18 1940, and that I last saw h-w alive on May 18 1940

Immediate cause of death	DURATION
Cerebral apoplexy	12 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Hyattsville Md Date signed 5/15/40

RECEIVED
MAY 27 1940
BUREAU V. S.

05628

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 230

1. PLACE OF DEATH:

County: Prince Geo

City or town: Ammendale
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Prince Geo

City or town: Ammendale Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. —
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Austin Fleming

3. (b) Social Security Number: —

4. Sex: F

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 68? Months: Days: If less than one day ... hrs. ... min.

9. Birthplace: Australia
(Town, county, and state)

10. Usual occupation: Catholic Priest

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: Normal Institute

Address: Ammendale Md.

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof: June 2/40
(month) (day) (year)

Cemetery or crematory: Ammendale

Location: Ammendale Md

18. Funeral director: Lloyd Carson

Address: Laurel Md.

19. June 1st 1940
(Date rec'd by registrar)

John D Smith
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5-30-1940 at 6 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-30-1940, to 5-30 1940 and that I last saw him alive on 5-30 1940

Immediate cause of death: Coronary Embolus

Due to

Due to

Other conditions: Hypertension

(Include pregnancy within 3 months of death)

DURATION: 5-30-40

1930

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE: B P Warren
M. D. or other

Address: Laurel

Date signed: 6-1-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05629

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Glenn Dale Sanatorium

Stay in hospital or inst. (yrs., or mos., or days): 2 yr 6 mo 16 dy

Stay in this community (yrs., or mos., or days): 2 yr 6 mo 16 dy

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 24 Franklin St. N. E.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: NO

3. (a) FULL NAME: Leroy Freeman

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife: Alley C. Freeman

6(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): Aug 29, 1887

8. AGE:

Years	Months	Days	If less than one day
52	8	24	____ hrs. ____ min.

9. Birthplace: Washington D.C. (Town, county, and state)

10. Usual occupation: Executive

11. Industry or business: administration

FATHER — 12. Name: John F. Freeman

FATHER — 13. Birthplace: Washington D.C.

MOTHER — 14. Maiden name: Margaret Strait

MOTHER — 15. Birthplace: Washington D.C.

16. Informant: deceased.

Address

17. Burial (Burial, cremation, or removal. Which?): Burial Date thereof: 5/25/40 (month) (day) (year)

Cemetery or crematory: St Marys

Location: Washington D C

18. Funeral director: Frank Evers Sons Co

Address: 1112-7 St Washington D C

19. May 23 1940 (Date rec'd by registrar) Leo V. Kinsella M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 23 1940, at 3:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 7 1937, to May 23 1940, and that I last saw him alive on May 23 1940.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	12 yr 4 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Dt operations

Of autopsy: No autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale Sanatorium Date signed: 5/23/40

Glenn Dale, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

CEIVED
JUN 4 1940
...REAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

05630

Reg. Dist. No. 239

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Prince Georges

City or town Laurel

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Prince George

City or town Laurel Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 45 A St

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR World war

3. (a) FULL NAME Leonard A Geiss

3. (b) Social Security Number none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 16th 1889

8. AGE: Years 50 | Months 9 | Days - | If less than one day hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Plumber

11. Industry or business

FATHER 12. Name Leonard J Geiss

13. Birthplace Md

MOTHER 14. Maiden name Rachael L. Timms

15. Birthplace Md

16. Informant George E. Divers

Address 44 A St Laurel Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 19th 40 (month) (day) (year)

Cemetery or crematory Ivy Hill

Location Laurel Md

18. Funeral director Lloyd Laird

Address Laurel Md

19. May 18 1940 (Date rec'd by registrar) Cora E. Wachter Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1940, at 12:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 ;

and that I last saw h alive on 19 .

Immediate cause of death	DURATION
Acute congestive heart failure	
Due to Cardio vascular renal diseases	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy none

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James H Boyd M. D. or other

Address Forestville Md Date signed 5-16-40

RECEIVED
JUN 1 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

05631

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Near Hyattsville, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days) 2 months

Stay in this community (yrs., or mos., or days) 2 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Montgomery

City or town Bethesda Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 117 Delray Ave.,
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Charles W. Gibbs.

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed.

6 (b) Name of husband or wife Mary M. Gibbs.

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) March 12, 1866

8. AGE: Years	Months	Days	If less than one day
74	1	30	____ hrs. ____ min.

9. Birthplace Mass.
(Town, county, and state)

10. Usual occupation Hardware Business (Retired)

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Miss Gladys E. Gibbs (Daughter)

Address 117 Delray Ave., Bethesda, Md.

17. Burrial (Burial, cremation, or removal. Which?) Date thereof 5/14/40 (month) (day) (year)

Cemetery or crematory Bridge Port, Conn.

Location Bridge Port, Conn.

18. Funeral director Wm. Rawson Purnphrey

Address Bethesda — Maryland

19. May 12 1940 (Date rec'd by registrar) Jas. Devere Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1940, at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5 1940, to May 11 1940, and that I last saw h. ive alive on May 11 1940.

Immediate cause of death	DURATION
arteriosclerosis	
Due to Cerebral hemorrhage with paralysis	1 mo.
Due to Myocardial degeneration	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of Injury ____ Injured at work?

23. SIGNATURE Thomas A. Christensen, M.D. M. D. or other

Address College Park, Md. Date signed May 11, 1940

RECEIVED
JUN 5 1940
BUREAU V. S.

05632

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH:

County Prince George

City or town Laurel (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 44 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Prince George

City or town Laurel Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 320 Compton Ave. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Howard Alonzo Gilbert

3. (b) Social Security Number

4. Sex M.

5. Color or race W.

6. (a) ~~Single, married~~, widowed, or ~~divorced~~ Widowed

6 (b) Name of husband or wife Georgeanna Gilbert

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23, 1851

8. AGE: Years 89 Months — Days 27 If less than one day hrs. min.

9. Birthplace Philadelphia, Pa (Town, county, and state)

10. Usual occupation Pressman

11. Industry or business U. S. Gov. Printing Office

FATHER 12. Name —

13. Birthplace —

MOTHER 14. Maiden name —

15. Birthplace

16. Informant Roland H. Gilbert

Address 320 Compton Ave. Laurel Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof May 22/40 (month) (day) (year)

Cemetery or crematory Ivy Hill

Location Laurel Md.

18. Funeral director Wilbert Donaldson

Address Laurel Md.

19. May 22 1940 (Date rec'd by registrar) M. Brashears Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 24 1935, to May 20 1940, and that I last saw him alive on May 20 1940.

Immediate cause of death Chronic myocarditis — DURATION 2 1/4 yr

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations None

Of autopsy None

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert S. McCeney M.D. M.D. or other

Address Laurel Md Date signed 5/22/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05633

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince Georges
City or town: Rural Near Glenn Dale
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Glenn Dale Sanatorium
Stay in hospital or inst. (yrs., or mos., or days): 1 yr - 30 days
Stay in this community (yrs., or mos., or days): same

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County: D.C.
City or town: Washington Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 1919 - 9½ St. N.W.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Dorothy Louise Gordon -
3. (b) Social Security Number: none

4. Sex: Female
5. Color or race: Colored
6. (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: —
6(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.): May 10, 1919

8. AGE: Years 21 | Months — | Days 20 | If less than one day ___ hrs. ___ min.

9. Birthplace: St. Mary's Co - Md -
(Town, county, and state)
10. Usual occupation: none - (Housework)
11. Industry or business: —
FATHER
12. Name: Robert Gordon -
13. Birthplace: Leonardtown Md.
MOTHER
14. Maiden name: Mary Herbert
15. Birthplace: St. Mary's Co. Md.
18. Informant: Deceased -
Address
17. Removal (Burial, cremation, or removal. Which?) Date thereof 5 - 31 - 40 (month) (day) (year)
Cemetery or crematory
Location: 15 Washington D.C.
18. Funeral director: Ernest Jones Inc
Address: 1432 [illegible] St. N.E.
19. May 31st 1940 (Date rec'd by registrar) Leo V. [illegible] M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 30 1940, at 8 45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/1 1939, to 5/30 1940, and that I last saw her alive on 5/30 - 1940.
Immediate cause of death: Pulmonary Tuberculosis — DURATION: 15 months
Due to —
Due to —
Other conditions —
(Include pregnancy within 3 months of death)
Major findings:
Of operations —
Of autopsy: none performed -

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?) — —
Means of injury — Injured at work? —

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale Sanatorium Glenn Dale, Md. Date signed 5/30/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164c)

CERTIFICATE OF DEATH

05634

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Prince Georges

City or town Brentwood

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 4407 Tuspect St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 6 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Brentwood Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 4407 Tuspect St

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Charles Keith Griffeth

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Marie Griffith

6(c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) May 12, 1910

8. AGE: Years	Months	Days	If less than one day
29	11	24	hrs. min.

9. Birthplace Colbert Ga

(Town, county, and state)

10. Usual occupation Barber

11. Industry or business

FATHER 12. Name Charles W Griffith

13. Birthplace Ga

MOTHER 14. Maiden name Hattie Porterfield

15. Birthplace Ga

16. Informant Marie Griffith

Address 4407 Tuspect St

17. Removal (Burial, cremation, or removal. Which?) Date thereof May 6, 1940 (month) (day) (year)

Cemetery or crematory Removal Washington DC

Location Washington D C

18. Funeral director E Gaschs Sons

Address Hyattsville Md

19. May 6 (Date rec'd by registrar) 1940 J Mc Norgle Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1940, at 8:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h__ alive on ____ 19__.

Immediate cause of death	DURATION
Hemorrhage	
Shock	
Due to Gunshot Wound	
through Chest.	
Due to	
Other conditions	
(Include pregnancy within 3 months of death)	

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Murder Date of 4-6-40

Where did injury occur? Brentwood (City or town) Prince (County) Md (State)

injured at home, farm, industry, public place (where?) home

Means of injury Gunshot injured at work?

23. SIGNATURE James H Boyd M. D. or other

Address Forestville Md Date signed 4-6-40

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JUN 3 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05635

(13-f)

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Glenn Dale Sanatorium

Stay in hospital or inst. (yrs., or mos., or days): 1 yr 7 mo 18 da

Stay in this community (yrs., or mos., or days): 18 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 309 New York Ave. N.W.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Eva Griffin

3. (b) Social Security Number: none

4. Sex: Female

5. Color or race: Negro

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John Ebert Griffin

6(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): August, 15 1901

8. AGE: Years: 38 Months: 9 Days: 1 If less than one day: hrs. min.

9. Birthplace: Johnson, S.C
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business:

FATHER
12. Name: Ben Sivingen
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Rebecca Parker
15. Birthplace: South Carolina

16. Informant: Hospital record

Address:

17. Removal to (Burial, cremation, or removal. Which?) Date thereof 5/17/40 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D.C.

18. Funeral director: Sidney Dyson

Address: 1308-6 St NW

19. May 17 1940 (Date rec'd by registrar) Leo V. Schneider M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16 1940, at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 28 1938, to May 16 1940, and that I last saw her alive on May 16 1940.

Immediate cause of death: Pulmonary tuberculosis — DURATION: 3½ yrs

Due to: Circulatory failure (post operative shock) — 4 hrs.

Due to: ~~Syphilis~~ Thoracoplasty, 2nd stage? C.W.S.R.

Other conditions:
(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale Sanatorium Glenn Dale, Md. Date signed 5/16/40

RECEIVED
JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22-a)

05636

CERTIFICATE OF DEATH

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Pro Georges County
City or town: WITHIN CORPORATE LIMITS Hyattsville Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 17 Ralston Ave
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 1 month

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pro Geo Co.
City or town: Hyattsville Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 17 Ralston ave
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: none

3. (a) FULL NAME: Charles Keller Hammer

3. (b) Social Security Number: none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife: Christine Foster Hammer
6(c) If alive, give age: 33 years

7. Birth date of deceased (mo., day, yr.): March 15, 1908

8. AGE: Years	Months	Days	If less than one day
32	2	9	— hrs. — min.

9. Birthplace: Hyattsville Md. (Town, county, and state)
10. Usual occupation: Farm Security
11. Industry or business: Government

FATHER
12. Name: J Keller Hammer
13. Birthplace: Penn

MOTHER
14. Maiden name: Annie Long
15. Birthplace: Washington D. C.

16. Informant: Christine Hammer
Address: Hyattsville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 27, 1940 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Washington D. C.

18. Funeral director: F. Gasch's Sons
Address: Hyattsville Md.

19. May 27 1940 (Date rec'd by registrar) Mrs. Jas. Devere Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24, 1940 at 9:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17 1940 to May 24 1940, and that I last saw h— alive on May 24 1940.

Immediate cause of death	DURATION
Miliary Tuberculosis	18 wks.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: C. Clark M.D. M. D. or other
Address: Hyattsville, Md. Date signed 5-25-40

RECEIVED
JUN 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131a)

CERTIFICATE OF DEATH

05637

Reg. Dist. No. 236

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Prince Georges

City or town Mitchellville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Franklin Davis Nursery

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 65

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Mitchellville Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Franklin Davis Nursery

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Samuel Harrison

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 65 | Months | Days | If less than one day hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Farm

FATHER 12. Name Manuel Harrison

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name Caroline Harrison

MOTHER 15. Birthplace Maryland

16. Informant Rhoda Shepherd

Address Mitchellville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 11 1940 (month) (day) (year)

Cemetery or crematory Woodmore Md

Location Woodmore Md

18. Funeral director Clarence Forcade

Address Mitchellville Md

19. May 10 1940 (Date rec'd by registrar) Effie B. Pumphrey Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1940, at 2:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 ,

and that I last saw h alive on 19 .

Immediate cause of death	DURATION
Intra cranial hemorrhage	
Due to Cardio vascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE James L Boyd M. D. or other

Address Forestville Md Date signed May 10 1940

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JUN 5 1940
BUREAU V. S.

05638

STATE OF MARYLAND—CERTIFICATE OF DEATH

1. PLACE OF DEATH (51-B)

County Prince Georges Co. Registration Dist. No. 246

Village or City Mt Rainier, Md No. 3822 - 31st St. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residance in city or town where death occurred 20 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME JOSEPH DENNIS HEARN If U. S. Veteran, specify WAR

(a) Residence: No. 3822 - 31 St., Ward. Social Sec. 214-01-7657

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: MALE

4. COLOR OR RACE: WHITE

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*): MARRIED

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Grace E

6. DATE OF BIRTH (month, day, and year) Jan 19, 1876

7. AGE: Years 64 | Months 4 | Days 6 | If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. RETIRED MECHANIC

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. AUTO MECHANIC

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Ohio

FATHER

13. NAME Michael Hearn

14. BIRTHPLACE (city or town) (State or country) Ireland

MOTHER

15. MAIDEN NAME Anna Field

16. BIRTHPLACE (city or town) (State or country) Ireland

17. INFORMANT Grace E Hearn (Address) 3822-31 St Mt Rainier Md

18. BURIAL, CREMATION, OR REMOVAL Place Cedar Hill Date 5/28, 1940

19. UNDERTAKER H. M. Padgett (Address) 131 - 11th St SE Wash DC

20. FILED May 25, 1940 Harry Kelley M D Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH MAY (Month) 25 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from 1-24, 1940, to 5-25, 1940

I last saw him alive on 5-24, 1940; death is said to have occurred on the date stated above, at 9:23 A.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Carcinoma of body 5th cervical vertebra

Date of onset

Other Contributory Causes of importance:

Primary/Carcinoma prostate: Duration: Unknown; but more than a year. CWGR.

Name of operation none Date of —

What test confirmed diagnosis? X-ray Was there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE. Home

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Herbert S Gates M. D.

(Address) 115 - 12 St. SE Wash., D.C.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE [redacted]LY, WITH UNFADING INK—THIS IS A PERMANENT RECO[redacted]ry item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

05639

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

Reg. Dist. No. 232

1. PLACE OF DEATH:

County Prince Georges

City or town upper Marlboro
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Prince Georges

City or town upper Marlboro Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Perry M. Henderson

3. (b) Social Security Number

4. Sex Male

5. Color or race colored

6 (a) Single, married, widowed, or divorced single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 2 1921

8. AGE: Years 18 Months 9 Days 8 If less than one day hrs. min.

9. Birthplace Washington D. C.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name Earnest E Henderson
13. Birthplace P. Geo. Co Md

MOTHER
14. Maiden name Laura Clark
15. Birthplace upper Marlboro Md

16. Informant Laura Henderson
Address upper Marlboro Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof May 14 1940
(month) (day) (year)

Cemetery or crematory union Cem Marlboro

Location upper Marlboro

18. Funeral director J. B. Johnson
Address Annapolis

19. May 14 1940 Grace Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1940, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 ,
and that I last saw h alive on 19 .

Immediate cause of death acute Pulmonary edema

Due to Pulmonary tuberculosis

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy same

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James H Boyd M. D. or other

Address Forestville Md Date signed 5-10-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T) (M)

RECEIVED
JUN 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 181

CERTIFICATE OF DEATH

05640

Reg. Dist. No. 230

1. PLACE OF DEATH:

County: Pro Georges County

City or town: Beltsville Maryland

(If outside city or town limits, write RURAL NEAR and giva town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Pro Geo County

City or town: Branchville Md. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: George H. Hofmann

3. (b) Social Security Number: 578-03-4546

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6 (b) Name of husband or wife: Emma Hofmann

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 30, 1901

8. AGE: Years: 38 years | Months: 11 | Days: 13 | If less than one day: hrs. min.

9. Birthplace: Washington D. C. (Town, county, and state)

10. Usual occupation: Automobile service man

11. Industry or business: Logan Motor Company Washington D. C.

FATHER 12. Name: Ferdinand Hofmann

13. Birthplace: Penna

MOTHER 14. Maiden name: Annie Schaeffer

15. Birthplace: New Jersey

16. Informant: Fred Hofmann

Address: Hyattsville Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof May 16, 1940 (month) (day) (year)

Cemetery or crematory: Fort Lincoln Cemetery

Location: Washington D. C.

18. Funeral director: F. Gasch's Sons

Address: Hyattsville Maryland.

19 May 15th 1940 (Date rec'd by registrar) John D Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13 1940, at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h alive on ____ 19__.

Immediate cause of death	DURATION
Burned	
Due to	
Due to	
Other conditions: Body reduced to a Charred mass	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? undetermined Date of 5-13-40

Where did injury occur? Beltsville (City or town) Pr Geo. (County) Md (State)

Injured at home, farm, industry, public place (where?) road

Means of injury Burned Injured at work?

23. SIGNATURE: James D. Boyd M. D. or other

Address: Forestville Md Date signed 5-15-40

(over)

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Identification is based on circumstances and body was burned to badly for positive identification.

The motive for this mans death is still being investigated

James D. Boyd.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05641

CERTIFICATE OF DEATH

Reg. Dist. No. 230

1. PLACE OF DEATH:
County: Prince Georges
City or town: Greenbelt
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Greenbelt Hospital - 30 B Ridge Road
Stay in hospital or inst. (yrs., or mos., or days): 4 days
Stay in this community (yrs., or mos., or days): 2 years.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Greenbelt Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 6 B Crescent Road.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Julia Larson Holt

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband ~~or wife~~: Charles Holt
6(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): January 21, 1861

8. AGE:

Years	Months	Days	If less than one day
79	3	15	____ hrs. ____ min.

9. Birthplace: Lillehammar, Norway (Town, county, and state)
10. Usual occupation: None
11. Industry or business: —
12. FATHER — Name: Ole J. Larson
13. FATHER — Birthplace: Norway
14. MOTHER — Maiden name: Unknown
15. MOTHER — Birthplace: Norway
16. Informant: Mrs. Clara H. Martin
Address: 6 B Crescent Rd. Greenbelt, Md
17. Removal burial (Burial, cremation, or removal. Which?) date thereof May 7, 1940 (month) (day) (year)
Cemetery or crematory: Mankato Cemetary
Location: Mankato, Minn.
18. Funeral director: Warner E. Pumphrey
Address: Silver Spring, Md.
19. May 6th 1940 (Date rec'd by registrar) John B. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6 1940, at 11:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 2 1940, to May 6 1940, and that I last saw h-er alive on May 6 1940.

	DURATION
Immediate cause of death: Cardiac failure due to	
Arteriosclerosis + Hypertension	
Heart Disease	
Due to	
Due to	
Other conditions	
(Include pregnancy within 3 months of death)	

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of: ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ____
Means of injury: ____ Injured at work?

23. SIGNATURE: Joseph M Szilagyi M. D. or other
Address: Greenbelt, Md Date signed: May 6, 1940

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-t) (P)

CERTIFICATE OF DEATH

05642

Reg. Dist. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:
County Prince Georges
City or town Glenn Dale
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Glenn Dale Sanatorium
Stay in hospital or inst. (yrs., or mos., or days) 8 mo - 20 d
Stay in this community (yrs., or mos., or days) 8 mo 20 d

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D. C. County
City or town Washington Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 136 - W - St. N.W
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME LeRoy Jackson

3. (b) Social Security Number 578-14-9896

4. Sex	5. Color or race	6(a) Single, married, widowed, or divorced
male	colored	Single

6 (b) Name of husband or wife

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 28, 1920

8. AGE: Years	Months	Days	If less than one day
19	4	24	hrs. min.

9. Birthplace Washington D. C.
(Town, county, and state)

10. Usual occupation Student

11. Industry or business

FATHER
12. Name Thomas Jackson
13. Birthplace Orange Virginia

MOTHER
14. Maiden name Julia Alexander
15. Birthplace Orange Virginia

16. Informant Deceased
Address

17. Removed (Burial, Cremation, or removal. Which?) Date thereof 5/23/40 (month) (day) (year)

Cemetery or crematory
Location Washington, D.C.

18. Funeral director H. S. Washington
Address 467 - N St. N.W.

19. May 23 1940 Leo V. Kinsside M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1940, at 3.25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 2 1939, to May 22 1940, and that I last saw him alive on May 22 1940.

Immediate cause of death Pulmonary Tuberculosis — DURATION 8 mo 20 d

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE David Leo Finucane M.D.
M. D. or other
Address Glenn Dale Sanatorium Date signed 5/22/40
Glenn Dale, Md.

RECEIVED
JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

05643

Reg. Dist. No. 235

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Pr. Geo. Co.

City or town Ritchie Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital or institution: Prince Georges Co. Alms House

Stay in hospital or inst. (yrs., or mos., or days) 8 years

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Pr. Geo Co.

City or town Glen Arden Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME George Thomas Johnson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6 (b) Name of husband or wife Mary Johnson

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) - - 1853

8. AGE: Years	Months	Days	If less than one day
87			hrs. min.

9. Birthplace Prince Geo. Co Md. (Town, county, and state)

10. Usual occupation Stable Man

11. Industry or business Race Track

FATHER 12. Name George Thomas Johnson

13. Birthplace Annapolis Md.

MOTHER 14. Maiden name Rebecka Chittams

15. Birthplace Annapolis Md.

16. Informant Deceased Above named

Address

17. Removal. (Burial, cremation, or removal. Which?) Date thereof 5-24-40 (month) (day) (year)

Cemetery or crematory

Location Washington D.C.

18. Funeral director M. T. Malvan

Address 424 - P. St N. W. D. C.

19. 5-24 19 40 Thos S Griffith

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 19 40, at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 19 32, to May 24 19 40, and that I last saw him alive on May 24 19 40

Immediate cause of death		DURATION
Cerebral hemorrhage		5 days
Due to arteriosclerosis	(Antecedent)	10 years
Due to Senility	(Antecedent)	10 years
Other conditions arteriosclerotic gangrene of left foot		2 weeks

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Smit Ritchie M. D. or other

Address Rte 1 Benning Rd D.C. Date signed May 24 1940

RECEIVED
JUL 5 1940
BUREAU V. S.

05644

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George

City or town: Glenn Dale (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Glenn Dale Sanatorium

Stay in hospital or inst. (yrs., or mos., or days): 2 yrs. 4 mos. 27 dos

Stay in this community (yrs., or mos., or days): 2 yrs. 4 mos 27 dos

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: District of Columbia County

City or town: Washington Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 2266 - 6th st., n.w (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: No

3. (a) FULL NAME: Eva Jones

3. (b) Social Security Number: None

4. Sex: Female

5. Color or race: Colored

6. (a) Single, married, widowed, or divorced: Married (separated)

6 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Aug. 15, 1909

8. AGE: Years: 30 Months: 9 Days: 3 If less than one day ____ hrs. ____ min.

9. Birthplace: Washington, D.C. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

FATHER

12. Name: John H. Brown

13. Birthplace: Virginia

MOTHER

14. Maiden name: Serena Callen

15. Birthplace: Virginia

16. Informant: deceased

Address: above

17. Removal (Burial, cremation, or removal. Which?) Date thereof 5/18/40 (month) (day) (year)

Cemetery or crematory

Location: Washington D.C

18. Funeral director: Thomas Frazier

Address: 389 R.I. ave. n.w. Wash. D.C

19. May 18 19 40 (Date rec'd by registrar) Leo V. Schneider M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 18 1940, at 6 50 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 21, 1932 1937, to May 18 1940, and that I last saw her alive on May 18 1940.

Immediate cause of death: Pulmonary Tuberculosis — DURATION: about 2 1/2 yrs.

Due to

Due to

Other conditions: None (Include pregnancy within 3 months of death)

Major findings:

Of operations: Thoracoplasty (rt.) Phrenicotomy (Lt)

Of autopsy

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale Sanatorium Date signed 5/18/40

Glenn Dale, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05645

Reg. Dist. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Glenn Dale Sanatorium
Stay in hospital or inst. (yrs., or mos., or days) 2 yrs. 2 mos. 6 dys
Stay in this community (yrs., or mos., or days) 2 yrs 2 mos 6 dys

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 6000 New Hampshire Ave
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: no

3. (a) FULL NAME: Robert Cornelius Jones

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife: Norma Wills Jones
Deceased 6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 5, 1865

8. AGE: Years	Months	Days	If less than one day
74	9	29	hrs. min.

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: Undertaker

FATHER 12. Name: Robert L. Jones
13. Birthplace: England

MOTHER 14. Maiden name: Julia O'Toole
15. Birthplace: Ireland

18. Informant: Deceased
Address: 6000 N.H. Ave

17. Removal (Burial, cremation, or removal. Which?) Date thereof 5-7-40 (month) (day) (year)
Cemetery or crematory: Removal
Location: Washington, D.C.

18. Funeral director: S.H. Hines Co.
Address: 2901-14th St. N.W.

19. May 7th 40 (Date rec'd by registrar) Leo V. Kluwide M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 7 1940, at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1938, to May 7 1940, and that I last saw h[im] alive on May 7 1940.

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 2 yrs 4 mos
Due to: from History
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. (M. D. or other)
Address: Glenn Dale Sanatorium Date signed 5/7/40
Glenn Dale Md

RECEIVED
JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05646

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince George
City or town: Bulavard Hgts, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 4322 Kingston ave
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Martin Joseph Keane

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Anna C Keane
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 10th 1870

8. AGE: Years	Months	Days	If less than one day
70	2	—	hrs. min.

9. Birthplace: Ireland (Town, county, and state)
10. Usual occupation: Retired Gov. Employee
11. Industry or business:
FATHER — 12. Name: Charles Keane
13. Birthplace: Ireland
MOTHER — 14. Maiden name: Unknown
15. Birthplace: Ireland
16. Informant: Mrs Anna C Keane
Address: 4322 Kingston Ave. Bulavard Hgts Md
17. Removal (Burial, cremation, or removal. Which?) Date thereof May 10th 1940 (month) (day) (year)
Cemetery or crematory:
Location: Washington, D.C.
18. Funeral director: W. W. Chambers Co
Address: 517 11th St S.E.
19. 5-10-1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1940, to May 10 1940, and that I last saw him alive on May 9 1940

Immediate cause of death	DURATION
Acute myocardial decompensation	May 5, 1940
Due to Chronic myocarditis	unknown
Due to General arteriosclerosis and Chronic alcoholism	unknown unknown
Other conditions —	—

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Autopsy none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Paul C Van Natta M. D. or other
Address: Bennings D.C. Date signed May 10 1940

RECEIVED
JUN 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

05647

CERTIFICATE OF DEATH

Reg. Dist. No. 240

1. PLACE OF DEATH:
County Prince George
City or town Cheltenham
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Geo.
City or town Cheltenham Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. —
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME William T. King

3. (b) Social Security Number none.

4. Sex: male
5. Color or race: white
6. (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife —
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.) Feb. 19-1866.

8. AGE: Years 74 Months 3 Days If less than one day ____ hrs. ____ min.

9. Birthplace Washington, D.C.
(Town, county, and state)
10. Usual occupation Tailor
11. Industry or business Cheltenham School for Boys
FATHER
12. Name Robert T. King
13. Birthplace Washington, D.C.
MOTHER
14. Maiden name Kate A. Gallagher
15. Birthplace Toronto, Canada.
16. Informant Mrs. Mary M. Paton
Address Cheltenham, Md.
17. Cremation (Burial, cremation, or removal. Which?) Date thereof May 24-40. (month) (day) (year)
Cemetery or crematory Cedar Hill Crematorium
Location Suitland, Md.
16. Funeral director Ritchie Brothers
Address Upper Marlboro, Md.
19. May 23 1940 (Date rec'd by registrar) T. H. Billingsley local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1940, at 4:30 10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 15 1940, to May 21 1940, and that I last saw him alive on May 21 1940.

Immediate cause of death Cardiac failure

Due to Cardio-vascular renal disease

Due to c̄ hypertensive carditis

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE George A. Weber, M.D. M. D. or other
Address Waldorf, Md Date signed 5/21/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A-15

RECEIVED
JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (16)

CERTIFICATE OF DEATH

05648
243
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Glenn Dale Sanatorium
Stay in hospital or inst. (yrs., or mos., or days): 6 mo 23 days
Stay in this community (yrs., or mos., or days): 25 yrs 6 mo 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: District of Columbia County:
City or town: Washington Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 1343 Fort Drive N.W.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Robert Lowhorn

3. (b) Social Security Number: 577-10-4408

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6 (b) Name of husband or wife: Mrs Cora Lowhorn
6(c) If alive, give age: 41 years

7. Birth date of deceased (mo., day, yr.): July 4 1894

8. AGE:

Years	Months	Days	If less than one day
45	10	18	____ hrs. ____ min.

9. Birthplace: Cavalton, Alabama (Town, county, and state)
10. Usual occupation: Janiter
11. Industry or business: Garage
FATHER 12. Name: Daniel Lowhorn
13. Birthplace: Cavalter, Ala
MOTHER 14. Maiden name: Henrietta Ferguson
15. Birthplace: Cavalter, Ala
16. Informant: Hospital record
Address:
17. Removal (Burial, cremation, or Removal. Which?) Date thereof: 5/23/40 (month) (day) (year)
Cemetery or crematory:
Location: Washington, D.C
18. Funeral director: Ernest Davis
Address: 1432 You St N W
19. May 23rd 1940 (Date rec'd by registrar) Lee V. Schneider M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 22 1940, at 4:05 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/29/39 19__, to 5/22/40 19__, and that I last saw him alive on 5/22/40 19__.

Immediate cause of death	DURATION
Tuberculosis of vertebral column	6 mo
Tuberculosis of genito urinary	6 mo
Due to Syphilis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: Destruction of spinal processes of lumber vertebrae
Of autopsy: Tuberculosis of spinal cord and ribs

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane MD M. D. or other
Address: Glenn Dale Sanatorium Date signed: 5/24/40
Glenn Dale, Md.

RECEIVED
JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05649

Reg. Dist. No. 230

1. PLACE OF DEATH:
County: Prince Georges
City or town: Gilen Delt
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Greenbelt Hospital - 30 B.R. & D. Rd.
Stay in hospital or inst. (yrs., or mos., or days): 42 hours
Stay in this community (yrs., or mos., or days): 42 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Washington D.C. County:
City or town: Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 2121 - 15 Street S.E.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Infant McAthy

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	S.

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 9, 1940

8. AGE: Years	Months	Days	If less than one day
		1 day 18 hrs.	hrs. min.

9. Birthplace: Greenbelt (Prince Georges) Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: William Barton McAthy
13. Birthplace: Carbondale, Illinois

MOTHER
14. Maiden name: Ruth Romayne Adams
15. Birthplace: Canonsburg, Pennsylvania

16. Informant: Mrs. William B. McAthy
Address: 2121 - 15 Street S.E. Wash. D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: May - 11 - 1940 (month) (day) (year)

Cemetery or crematory: Greenbelt Md.

Location: Greenbelt Cemetery

18. Funeral director: H. Finch & Co.

Address: Washington D.C.

19. May - 11th - 1940 (Date rec'd by registrar) John D. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10 1940, at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 9 1940, to May 10 1940, and that I last saw h- alive on May 10 1940.

Immediate cause of death	DURATION
Confluent bronchopneumonia	
Due to - organism undetermined	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

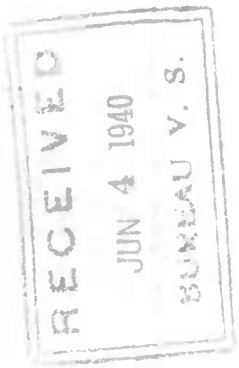
23. SIGNATURE: Joseph Szilagyi M. D. or other
Address: Greenbelt Md. Date signed: 5.11.40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Mr. John Smith



STATE OF MARYLAND—CERTIFICATE OF DEATH

05650

(177)

1. PLACE OF DEATH

County Pr. Geos Registration Dist. No. 233

Village or City Brandywine No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U.S. if of foreign birth? ___ yrs. ___ mos. ___ ds.

2. FULL NAME Jamie C. Martin If U. S. Veteran, specify WAR

(a) Residence: No. Brandywine Md. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Pliny Martin

6. DATE OF BIRTH (month, day, and year): Apr 15 - 1856

7. AGE: Years 84 | Months 0 | Days 27 | If LESS than 1 day, ___ hrs. or ___ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Housewife

10. Date deceased last worked at this occupation (month and year): 1940

11. Total time (years) spent in this occupation: 60

12. BIRTHPLACE (city or town) (State or country): Chas Co Md

FATHER

13. NAME: Hezekiah Ward

14. BIRTHPLACE (city or town) (State or country): Chas Co Md

MOTHER

15. MAIDEN NAME: Bertha Hunt Ward

16. BIRTHPLACE (city or town) (State or country): Chas Co Md

17. INFORMANT (Address): Mrs W. E. Hunt Waldorf Md.

18. BURIAL, CREMATION, OR REMOVAL

Place: Mallawoman Date: May 14, 1940

19. UNDERTAKER (Address): Hunt & Ryan Waldorf Md

20. FILED May 13, 1940 Ernest W. Garner Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH May (Month) 13 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from May 13, 1940, to May 13, 1940

I last saw deceased alive on May 13, 1940; death is said to have occurred on the date stated above, at 10 P. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Angina Pectoris

Date of onset

Other Contributory Causes of importance:

Ptomain Poison; caused by eating home-canned sausage. [illegible]

Name of operation: Duration: 2 to 9 P.M. Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) [illegible] M. D.

(Address) Aquasco Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

RECEIVED
JUN 3 1929
BUREAU V. S.

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05651

Reg. Dist. No. 238

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince Georges Co.

City or town: Fort Foote

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Pr. Geos Co.

City or town: Fort Foote Md. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.:

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Lemuel a. Martin

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife: maggie H. Martin

6(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): July 23rd 1868

8. AGE: Years: 71 Months: 9 Days: 17 If less than one day: hrs. min.

9. Birthplace: Fort Foote md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER

12. Name: Francis Martin

13. Birthplace: Fort Foote md.

MOTHER

14. Maiden name: Mary Frye.

15. Birthplace: unknown.

16. Informant: Mrs. maggie H. Martin

Address: Fort Foote Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 13-40 (month) (day) (year)

Cemetery or crematory: Fort Lincoln

Location: Pr. Geos Co.

18. Funeral director: Thomas F. Murray

Address: 2007 - Nicholas ave S.E. Washington D.C.

19 May 11 19 40 Harry E. Lyles

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10 19 40 at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 19 40, to May 9 19 40, and that I last saw h alive on May 10 19 40

Immediate cause of death	DURATION
Cerebral Thrombosis	
Due to Arteriosclerosis	
Due to	
Other conditions Bronchopneumonia	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Ernest W Schwartz M.D. or other

Address: Date signed:

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JUN 7 1960
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

05652

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH (159)

County Prince George Registration Dist. No. 239

Village or City Laurel, Md. No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residanca in city or town where daath occurrad yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Baby Girl Matthews If U. S. Veteran, specify WAR

(a) Residence: No. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write tha word)
F	B	Single

5a. If marriad, widowad, or divorcad
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and yaer) May 25, 1940

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				12

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. —

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. —

10. Date daceased last workad at this occupation (month and yeer)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Laurel Md.
(State or country)

FATHER

13. NAME George Matthews

14. BIRTHPLACE (city or town) Laurel, Md.
(State or country)

MOTHER

15. MAIDEN NAME Susie Cajer

16. BIRTHPLACE (city or town) Laurel, Md.
(State or country)

17. INFORMANT Susie Cagar Laurel Md
(Address)

18. BURIAL, CREMATION, OR REMOVAL
Place Contee Shades Cem Date May 27, 1940

19. UNDERTAKER Richard Gibson
(Address) Laurel Md

20. FILED May 26, 1940 M. V. Brashears Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH May (Month) 25 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from
, 19 , to , 19

I last saw h[illegible] aliva on May 25, 1940; death is said to have occurrad on the date stated above, at 11 P m.

The **PRINCIPAL CAUSE OF DEATH** and raletad causes of importanca were as follows:

	Date of onset
Premature Birth	

Dther **Contributory Causes** of importance:

Name of operation Dete of

What test confirmad diagnosis? Was thare an autopsy?

23. If daeth was dua to axternel causes (VIDLENCE) fill in also the following:

Accident, suicida, or homicide? Date of Injury , 19

Where did Injury occur?
(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, In HOME, or in PUBLIC PLACE.

Manner of Injury

Neture of Injury

24. Was disease or injury in any wey related to occupetion of deceased?

If so, specify

(Signed) J. McMorris M. D.

(Address) Laurel, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, **not** the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The **principal cause of death** and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other **contributory causes of importance:**	
Gallstones	*May 1, 1923*

Example II

The **principal cause of death** and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05653

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince George
City or town: Cottage City
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Prince George County: Md.
City or town: Cottage City Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 1 Bunker Hill Rd.
(If rural give LOCATION)
2(c) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Joseph Vernon Mattingly

3. (b) Social Security Number: none

4. Sex: M
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Essie Evelyn Mattingly
6(c) If alive, give age: 56 years
7. Birth date of deceased (mo., day, yr.): May 10, 1885
8. AGE: Years: 55 Months: - Days: 9 If less than one day: hrs. min.
9. Birthplace: Washington D.C.
(Town, county, and state)
10. Usual occupation: Plumber
11. Industry or business
FATHER 12. Name: Joseph William Mattingly
13. Birthplace: Washington D C
MOTHER 14. Maiden name: Ella Sydnor
15. Birthplace: Washington D C.
16. Informant: Essie E. Mattingly
Address: 1 Bunker Hill Rd
17. Burial, cremation, or removal. Which?: Burial Date thereof: (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Cottage City
18. Funeral director: Deal Funeral Home
Address: 4812 Gallatin Wash D C
19. (Date rec'd by Registrar): May 19, 1940
M. S. Richardson Asst Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 19, 1940, at 3:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-15-1940, to 5-19-1940, and that I last saw h[illegible] alive on 5-19-1940.

Immediate cause of death: Lobar Pneumonia — DURATION
Right upper & middle Lobe
Due to: Hypertension Arteriosclerotic
Heart & kidney disease
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Geo. L. Hagerage M. D.
M. D. or other
Address: 23 Bulls Blvd Date signed: 5-19-40

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JUN 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05654

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George
City or town: Glenn Dale
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Glenn Dale Sanatorium
Stay in hospital or inst. (yrs., or mos., or days): 2 yr. 9 mos. 19 das.
Stay in this community (yrs., or mos., or days): 2 yr. 9 mos. 19 das.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: District of County: Columbia
City or town: Washington Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 629 - 4th St., N.E.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: No

3. (a) FULL NAME: Johnny McKie

3. (b) Social Security Number: None

4. Sex: Male
5. Color or race: colored
6. (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: —
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): Aug. 17, 1915

8. AGE: Years: 24 | Months: 8 | Days: 19 | If less than one day: ____ hrs. ____ min.

9. Birthplace: So. Carolina (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:
FATHER
12. Name: Bossie McKie
13. Birthplace: So. Carolina
MOTHER
14. Maiden name: Lucinda Blossengill
15. Birthplace: So. Carolina
16. Informant: deceased
Address: above
17. Removal to (Burial, cremation, or removal. Which?) Date thereof: May 6, 1940 (month) (day) (year)
Cemetery or crematory:
Location: Washington, D.C.
18. Funeral director: H. S. Washington & Son
Address: 467 - N St. N.W.
19. May 6th 1940 (Date rec'd by registrar) Leo V. Schneider M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6 1940, at 5:25 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 21 1937, to May 6 1940, and that I last saw him alive on May 6 1940.

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 5 yrs.
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale Sanatorium Date signed: 5/6/40
Glenn Dale, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05655

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince Georges

City or town Glenn Dale, Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Glenn Dale Sanatorium

Stay in hospital or inst. (yrs., or mos., or days) 6 yrs.

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State DC County

City or town Washington Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 1632 - 33rd St. N.W.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR none

3. (a) FULL NAME James Papps

3. (b) Social Security Number none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife Single

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 22, 1888

8. AGE:

Years	Months	Days	If less than one day
51	6	13	hrs. min.

9. Birthplace Greece (Town, county, and state)

10. Usual occupation Waiter

11. Industry or business Restaurant

FATHER 12. Name Ernest Papps

13. Birthplace Greece

MOTHER 14. Maiden name unknown

15. Birthplace Greece

16. Informant Deceased

Address 1632 - 33rd ST N W

17. Removal (Burial, cremation, or removal. Which?) Date thereof 5/5/40 (month) (day) (year)

Cemetery or crematory

Location Washington, D.C.

18. Funeral director W. W. Chambers

Address 1400 Chapin St., N.W. Wash., D.C.

19. May 5th 1940 (Date rec'd by registrar) Les V. Schneider M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5th 1940, at 3.55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 12th 1934, to May 5th 1940, and that I last saw him alive on May 5th 1940.

Immediate cause of death Pulmonary Tuberculosis

DURATION 6 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel Leo Finucane M.D. M. D. or other

Address Glenn Dale Sanatorium Date signed 5/5/40

Glenn Dale, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 4 1940
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

05656

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince George

City or town: Hyattsville (Rural Near)
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Sacred Heart Home

Stay in hospital or inst. (yrs., or mos., or days): Since Feb 1928

Stay in this community (yrs., or mos., or days): Since Feb 1928

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: County:

City or town: Washington D.C. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 1436 - W. N.W.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Alice Quinn

3. (b) Social Security Number:

4. Sex: female

5. Color or race: white

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1858 no month or day

8. AGE: Years: 82 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Ireland
(Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business: Probably Domestic

FATHER
12. Name: John Quinn
13. Birthplace: Ireland

MOTHER
14. Maiden name: Rose McAnnelly
15. Birthplace: Ireland

16. Informant: Deceased

Address: Sacred Heart Record

17. removal
(Burial, cremation, or removal. Which?)

Date thereof: May 12" 1940
(month) (day) (year)

Cemetery or crematory:

Location: 475 H. St N.W. Wash. D.C.

18. Funeral director: P. J. Saffell

Address: 475 - H. N.W. Wash. D.C.

19. May 12" 1940
(Date rec'd by registrar)

Registrar: Mrs. Jas. Devine Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12 1940, at 3 30 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1928, to May 12 1940, and that I last saw her alive on May 11 1940.

Immediate cause of death: acute cardiac dilatation — DURATION: 5/10/40

Due to: Generalized arteriosclerosis — 8 yrs.

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations: None

Of autopsy: None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Thomas E Mattingly MD
M. D. or other

Address: 2200 R. Ave NE Date signed: 5/12/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (163-0)

CERTIFICATE OF DEATH

05657

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince Georges

City or town Brentwood
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 3401 Campbell

Stay in hospital or insf. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Brentwood Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 3401 Campbell
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Irene Catherine Rudy

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1904

8. AGE:

Years	Months	Days	If less than one day
36	0	5	hrs. min.

9. Birthplace Baker W. Va.
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER
12. Name James Rudy
13. Birthplace W. Va.

MOTHER
14. Maiden name Mary Oates
15. Birthplace W. Va.

16. Informant Roy Rudy

Address Cumberland Md

17. Transportation (Burial, cremation, or removal. Which?) Date thereof May 15, 1940 (month) (day) (year)

Cemetery or crematory Cumberland Md

Location Cumberland Md

18. Funeral director F Gasch's Sons

Address Hyattsville Md

19. May 15 1940 (Date rec'd by registrar) F Mrs Norgle LOCAL Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1940, at 2:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 ,

and that I last saw h alive on 19 .

Immediate cause of death Carbon Monoxide Poisoning

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 5-15-40

Where did injury occur? Brentwood (City or town) Pr Geo (County) Md (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James H Boyd M. D. or other

Address Forestville Md Date signed 5-15-40

VS A15 (T) MARGIN RESERVED FOR BINDING (I) (M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05658

CERTIFICATE OF DEATH

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince Geo Co.
City or town: College Park, Colesville Rd.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: P. G.
City or town: College Park Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Eugene Wade Shreve

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb 28, 1940

8. AGE:

Years	Months	Days	If less than one day
	2	26	hrs. min.

9. Birthplace: Md. Garrett Co.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Benjamin Shreve
13. Birthplace: West Va.

MOTHER
14. Maiden name: Mildred Friend
15. Birthplace: Md.

16. Informant: Benjamin Shreve
Address: College Park Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 28, 1940 (Month) (day) (Year)
Cemetery or crematory: Layerville Cemetery
Location: Oakland Md.

18. Funeral director: L. Gaeche Sons
Address: Hyattsville Md.

19. May 27th 1940 Mrs. Jas. Reeves Deputy Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 26 1940, et M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 25 1940 to 19; and that I last saw h~~im~~ alive on May 26 1940

Immediate cause of death	DURATION
(a) Cerebral Abscess	
Due to (b) Sinus Thrombosis	
Due to (c) Mastoiditis	
Due to (d) Otitis Media	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Martin Keane M. D. or other
Address: Riverdale Date signed 3/26/40

Commerce office notified. & approved

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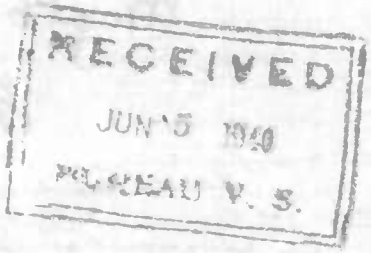
JUN 5 1940
BUREAU V. S.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

05659

Reg. Dist. No. 232

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Prince Georges
City or town Croome (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md County Prince Georges Co
City or town Croome Ward No. (If outside city or town limits, write RURAL NEAR and give town)
Street No. (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Alice Simmons

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	married

6 (b) Name of husband or wife Benjamin Simmons
6(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) April 14 1878

8. AGE: Years	Months	Days	If less than one day
62	1 mo	5	hrs. min.

9. Birthplace Md (Town, county, and state)
10. Usual occupation Home Wife
11. Indusfry or business
FATHER 12. Name William Brown
13. Birthplace Md
MOTHER 14. Maiden name Nancy Bans
15. Birthplace Md
16. Informant Helen Brown
Address Croom Md
17. (Burial, cremation, or removal. Which?) Date thereof 5/20/40 (month) (day) (year)
Cemetery or crematory Rosaryhille Md.
Location
18. Funeral directfor Robert S. McGuire
Address 1820-9th St N.W.
19. May 16 1940 (Date recd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1940, at 8:15 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 8 1940, to May 16 1940, and that I last saw h-e alive on May 15 1940.

Immediate cause of death	OURATION
Acute Congestive heart failure	
Due to Cardio vascular renal	
Due to disease	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN Please underline the cause fo which death should be charged statistically.

22. VIOLENCE: If death was due fo external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James D. Boyd M. D. or other
Address Forestville Md Date signed 5-16-40

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STATE OF MARYLAND—CERTIFICATE OF DEATH

05660

1. PLACE OF DEATH (94a)

County Prince George Registration Dist. No. 245

Village or City Mt Rainier No. 3726 - 31st St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Forrest Edgar Stansbury

(a) Residence: No. 3726 - 31st St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Moggie May Withers

6. DATE OF BIRTH (month, day, and year): Jan 26st 68

7. AGE: Years 72 Months 34 Days 27 If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: Machinist

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: Navy yard

10. Date deceased last worked at this occupation (month and year): Retired

11. Total time (years) spent in this occupation:

12. BIRTHPLACE (city or town) (State or country): Prince Geo Co Md

FATHER

13. NAME: Wm Wallace Stansbury

14. BIRTHPLACE (city or town) (State or country): Md

MOTHER

15. MAIDEN NAME: Mary S Thorne

16. BIRTHPLACE (city or town) (State or country): Md

17. INFORMANT (Address): Mrs Norma Lloyd 3726 - 31st

18. BURIAL, CREMATION, OR REMOVAL: Congressional Cem

Place: Washington, D.C. Date: 5-25, 1940

19. UNDERTAKER (Address): F. Gaschi Sons. Hyattsville Md.

20. FILED: May 25, 1940 Mrs Jas. Severe Deputy Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH May (Month) 23 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Jan 10, 1940, to May 23, 1940

I last saw him alive on May 22nd, 1940; death is said to have occurred on the date stated above, at 8:25 P.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Angina pectoris	1925
Other Contributory Causes of importance:	
Arteriosclerosis & Myocarditis	1939

Name of operation: 0 Date of

What test confirmed diagnosis? 0 Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following: 0

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) R W Conklin M. D.

(Address) 3100 - 20 - N.E.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

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U. S.

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-1)

CERTIFICATE OF DEATH

05661

Reg. Dist. No. 238

1. PLACE OF DEATH:
County ~~Co~~ Prince George
City or town ~~#~~ Friendly, Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: —
Stay in hospital or inst. (yrs., or mos., or days) —
Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Friendly Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Anacostia D.C. R#2
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR no

3. (a) FULL NAME Raymond Brazil Talbert

3. (b) Social Security Number

4. Sex: Male
5. Color or race: W
6. (a) Single, Married, widowed, or divorced: Separated
6 (b) Name of husband or wife: Jennie Elizabeth Talbert
6(c) If alive, give age: 51 years
7. Birth date of deceased (mo., day, yr.): July 19 1883
8. AGE: Years 56 Months — 10 Days — 20 If less than one day ____ hrs. ____ min.
9. Birthplace: Prince George Co (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Rents and Trucks
FATHER 12. Name: Silas Perkins Talbert
13. Birthplace: Unknown.
MOTHER 14. Maiden name: Jessie Talbert
15. Birthplace: Unknown.
16. Informant: Wm Talbert
Address: R#2 Anacostia D.C.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 11-40 (month) (day) (year)
Cemetery or crematory: M. E. Church Cemetery
Location: Oxon Hill Maryland
18. Funeral director: Thomas F. Murray
Address: 2007 Nichols ave S.E. Wash D.C.
19. May 10 1940 (Date rec'd by registrar) Harvey E. Myles Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1940, at 5.25 P.M.
I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1940, to May 9 1940, and that I last saw ~~him~~ her alive on May 8 1940.

	DURATION
Immediate cause of death: Chronic Myocarditis with acute myocardial failure	10 days
Due to: Chronic endocarditis	Unknown
Due to: Chronic Hypertrophic arthritis	Unknown
Other conditions: Secondary anemia	Unknown

(Include pregnancy within 3 months of death)

Major findings:
Of operations: none
Of autopsy: none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no
Accident, suicide, or homicide — Date of
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE Paul C Van Valla M. D. ~~or other~~
Address Bennings D.C. R#1 Date signed May 9 1940

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JUN 7 1940
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

CERTIFICATE OF DEATH

05662

Reg. Dist. No. 236

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince Georges
City or town: Mitchellville Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or insf. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): Z

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Mitchellville Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: — Thompson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col	—

6 (b) Name of husband or wife: —
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 21 1940

8. AGE: Years | Months | Days | If less than one day: hrs. min.

9. Birthplace: Mitchellville Md
(Town, county, and state)

10. Usual occupation: —

11. Industry or business:

FATHER
12. Name: James Thompson
13. Birthplace: Prince Georges Co

MOTHER
14. Maiden name: Rosa Savoy
15. Birthplace: Charles Co Md

16. Informant: James Thompson
Address: Mitchellville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 22 1940 (month) (day) (year)
Cemetery or crematory: Cemetery, M. Farm
Location: Mitchellville

18. Funeral director: James Thompson
Address: Mitchellville, Md.

19. May 21 19 40 (Date rec'd by registrar) Effie B. Pumphrey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 21 19 40, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19, and that I last saw h alive on 19.

Immediate cause of death: Born Dead — DURATION

Due to:

Due to:

Other conditions:
(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Kennedy Sansom M. D. or other
Address: Upper Marlboro Md Date signed

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BUREAU V. S.

05663

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13Fa)

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County 123 Balto Blvd. P.H.Co.

City or town Colma Manor.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State County

City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Ida Vendemia

3. (b) Social Security Number

4. Sex F.

5. Color or race W.

6. (a) Single, married, widowed, or divorced widow

6 (b) Name of husband or wife Joseph Vendemia

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 11, 1864

8. AGE: Years 75 Months 6 Days 1 If less than one day hrs. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Crespi
13. Birthplace Italy

MOTHER
14. Maiden name Marianne
15. Birthplace Italy

16. Informant Tony Vendemia
Address 411 1/2 - 7 - st Sw.

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory Washington, D.C.
Location " "

18. Funeral director H. J. Tattarull
Address 436-7 st Sw. Wash DC

19. May 2 1940 (Date rec'd by registrar) F. McNorgle LOCAL Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-1- 1940, at 9:50 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 3 1939, to May 1 1940, and that I last saw her alive on May 1 1940.

Immediate cause of death Cerebral Apoplexy

DURATION 5-1-40

Due to Arteriosclerotic Heart and kidney disease

Due to Hypertension.

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide — Date of
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE George J Hagerage M. D.
M. D. or other
Address 23 Balto Blvd Date signed 5-2-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

05664

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Prs Geo Co
City or town University Park Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
109 Monroe at.)
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 1 year

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Pro
City or town University Park Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 109 monroe st
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR No

3. (a) FULL NAME Max W. Von Bernewitz

3. (b) Social Security Number No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Dorothea Von Bernewitz
6(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) July 15. 1878

8. AGE: Years	Months	Days	If less than one day
61	10	3	hrs. min.

9. Birthplace New Zeland
(Town, county, and state)
10. Usual occupation Mining Engineer
11. Industry or business
FATHER 12. Name Max Jr. Von Bernewitz
13. Birthplace Germany
MOTHER 14. Maiden name Hedwig von Recklenau
15. Birthplace Germany
16. Informant Dorothea Von Bernewitz
Address 109 Monroe St.
17. Cremation Date thereof May 21, 1940
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Forest Lincoln Cemetery
Location Washington D.C.
18. Funeral director L. Blasche Long
Address Hyattsville Md
19. May 19 1940 M. D. Richardson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1940, at 8 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1939, to May 18 1940
and that I last saw him alive on May 18 1940

Immediate cause of death	DURATION
Acute Left Ventricular Failure	20 min.
Due to Myocarditis	
Due to	
Other conditions Hypertensive Cardio-Vascular Renal Disease.	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE William F. Luckett M.D.
M. D. or other
Address 1419 R.I. Ave N.W. Date signed May 18 1940

RECEIVED
JUN 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05665

Reg. Dist. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince George
City or town: Glenn Dale
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Glenn Dale Sanatorium
Stay in hospital or inst. (yrs., or mos., or days) 1 yr. 9 mo. 1 da.
Stay in this community (yrs., or mos., or days) 1 yr. 9 mo. 1 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: District of Columbia County: Columbia
City or town: Washington Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 1125 - 3rd st., n.w.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: No

3. (a) FULL NAME: Thelma Washington

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	Colored	Married (separated)

6 (b) Name of husband ~~or wife~~: Raymond Washington

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Jan. 8, 1917

8. AGE:

Years	Months	Days	If less than one day
23	4	17	____ hrs. ____ min.

9. Birthplace: Washington, D.C. (Town, county, and state)
10. Usual occupation: Waitress
11. Industry or business: Restaurant

FATHER
12. Name: Freddie Clemons
13. Birthplace: Washington, D.C

MOTHER
14. Maiden name: Carrie Peyton
15. Birthplace: Washington, D.C.

16. Informant: Deceased
Address: above

17. Removal To (Burial, cremation, or removal. Which?) Date thereof 5/27/40 (month) (day) (year)
Cemetery or crematory
Location: Washington, D.C.

18. Funeral director: Wm T. Talbot
Address: 308-6th St. N.W. Washington D.C.

19. May 28 1940 (Date rec'd by registrar) Leo V. Kilmeade M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25 1940, at 3:08 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 24 1938, to May 25 1940, and that I last saw h~~er~~ alive on May 25 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	4 yrs. +
Due to	
Due to	
Other conditions: Syphilis	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: None
Of autopsy: None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: Daniel Leo Finucane MD M. D. or other
Address: Glenn Dale Sanatorium Date signed 5/25/40
Glenn Dale, Md.

RECEIVED
JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05666

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Glenn Dale Sanatorium
Stay in hospital or inst. (yrs., or mos., or days): 1yr - 10mo - 18d
Stay in this community (yrs., or mos., or days): 1yr - 10mo - 18d

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 938 - 24th St N.W
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Leonard Rudolphus Williams

3. (b) Social Security Number: 709-14-6922 (Poss.)

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	Single

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 27, 1906

8. AGE:

Years	Months	Days	If less than one day
33	7	4	hrs. min.

9. Birthplace: Cosanova Virginia
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business
FATHER 12. Name: James Williams
13. Birthplace: Cosanova, Virginia
MOTHER 14. Maiden name: Fannie Sinclair
15. Birthplace: Cosanova Virginia
16. Informant: Deceased
Address
17. Removal (Burial, cremation, or removal. Which?) Date thereof 6/1/40 (month) (day) (year)
Cemetery or crematory:
Location: Washington, D.C.
18. Funeral director: Thomas Frazier
Address: 389 Rhode Island Ave, N.W., Wash. D.C.
19. June 1st 1940 (Date rec'd by registrar) L. V. Almeida M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 31 1940, at 8:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 13 1938, to May 31 1940, and that I last saw him alive on May 31 1940.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy: None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: David Leo Pincans M.D.
M. D. or other
Address: Glenn Dale Sanatorium Date signed: 5/31/40
Glenn Dale, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V8 A16

RECEIVED
JUN 4 1940
BUREAU V. S.